Specialty
Intrathecal Pump Management
Spasticity and Pain

JCAHO ACCREDITED PHARMACY

Prometra MRI Support Visit Request Form

Patient Info:

Name ____________________ DOB ___/___/____ SSN ____________________
Address ____________________ City ____________________ State______ Zip____________
Phone #____________________ Email ____________________ Diagnosis ____________________
Is patient currently getting pump refilled *at home or in MD office*: ____________________
Emergency Contact ____________________ Relationship ______________ Phone #______________

Insurance

Primary Insurance ____________________ Policy# ____________________ Group#______________
Policy Holder ______________ DOB____/____/____Relationship to PT ____________________
Phone # (on ID card) ______________

Name and Location where MRI will be performed:

MRI Center Name____
Address: ____
Phone #____________________ Preferred Date and Time of MRI____________________

Referral Source

Name/Title of sender: ____________________ MD Name ____________________
MD Address ____
MD Phone #____

EMAIL BHI's Monitoring Center (monitoringcenter@basichi.com):

- **Completed MRI support visit request form**
- **Copy of insurance card**
- **Most recent telemetry**